

Patient Name:  
Date of Birth:  
MRN:

Office Use Only



# Stony Brook Medicine

## Stony Brook Psychiatric Associates, P.C. Psychiatry Outpatient Services Patient Information

As part of our assessment, we want to understand who you are as a person. We want to hear about your goals, your strengths and skills and the challenges that you have overcome. We also want to learn about any issues that you want to address as a part of your treatment. We will work closely with you to develop an individualized plan for your care. **Please place a check mark next to any of the items below that you would like us to discuss and address in this treatment planning process.** Also, place a check mark next to any issues that might make it challenging for you to participate in your treatment.

Personal care skills	
Coping skills	
Communication skills	
Social skills	
Employment	
Education	

Family relationships	
Family stressors	
Support networks	
Physical or dental health	
Smoking cessation	
Weight or eating problems	

Sleep difficulties	
Sexual difficulties	
Fear of falling	
Anger management problems	
Thoughts of harming yourself	
Thoughts of harming others	

Housing concerns	
Transportation concerns	
Insurance or other benefits	
Cultural issues	
Spiritual or religious issues	
Legal problems	

### Fill in the blanks and circle any answers that apply to you.

Describe any other issues that you would like to have addressed: \_\_\_\_\_

How do you learn best about new topics? Seeing                      Hearing                      Doing                      No preference

What language do you prefer for written information? \_\_\_\_\_

What language do you prefer for spoken information? \_\_\_\_\_

Do you have problems with hearing or eyesight that would affect learning? Yes      No

Are you experiencing any pain? Yes      No      If yes, describe: \_\_\_\_\_

Do you have a medical advance directive? Yes      No

Do you have a psychiatric advance directive? Yes      No

Do you have a health care proxy? Yes      No

Do you have a preference about your treatment? No preference                      Self-help                      Psychotherapy                      Medication

Would you like information about your diagnosis? Yes      No                      Would you like information about your treatments? Yes      No

Would you like your family to have information about your diagnosis or treatment? Yes      No

**In the box below, please tell us about the skills that you have and what things make you happy or proud about yourself. Also, tell us your goals of what you would like to do in the future.**

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What allergies do you have? \_\_\_\_\_

What is your current weight? \_\_\_\_\_

What is your current height? \_\_\_\_\_

Are there any changes in your physical health that we should be aware of? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please complete these questions about your use of tobacco, alcohol and drugs by circling your answer.

Are you a smoker?					
Yes	No				
Have you ever been a smoker?					
Yes	No				
Do you use any other types of tobacco products, such as cigars, pipes, or chewing tobacco?					
Yes	No				
How often did you have a drink containing alcohol in the past year?					
Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
How many drinks did you have on a typical day when you were drinking in the past year?					
I do not drink	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often did you have six or more drinks on one occasion in the past year?					
Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

The following questions concern information about your use of drugs other than alcohol and tobacco during the **past 12 months**. Carefully read each statement and mark your answer as "Yes" or "No" in the appropriate box. When the words "drug abuse" are used, they mean the use of prescribed or over-the-counter medications in non-directed ways and any non-medical use of drugs. Classes of drugs may include: cannabis (i.e. marijuana), tranquilizers (i.e. Valium/Xanax), solvents, barbiturates, cocaine, stimulants (i.e. speed), hallucinogens (i.e. LSD) or narcotics (i.e. heroin). Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right. Remember that the questions refer to the **past 12 months** and do not include alcohol or tobacco.

	Yes	No
Have you used drugs other than those required for medical reasons?		
Do you abuse more than one drug at a time?		
Are you always able to stop using drugs when you want to?		
Have you had "blackouts" or "flashbacks" as a result of drug use?		
Do you ever feel bad or guilty about your drug use?		
Does your spouse (or parents) ever complain about your involvement with drugs?		
Have you neglected your family because of your use of drugs?		
Have you engaged in illegal activities in order to obtain drugs?		
Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?		
Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?		

(Questions are from the AUDIT-C version of the Alcohol Use Disorders Identification Test, published in Addiction 88: 791-804, 1993 and the DAST-10 version of the Drug Abuse Screening Test developed by Harvey A Skinner and published in Addictive Behavior 7(4):363-71, 1982.)